Quality is Our Bottom Line

Insurance and Real Estate Committee

Public Hearing

March 18, 2021

Connecticut Association of Health Plans

Testimony on

HB 6622 AN ACT CONCERNING PRESCRIPTION DRUG FORMULARIES AND LISTS OF COVERED DRUGS

The Connecticut Association of Health Plans opposes HB 6622 which prohibits health insurers from removing a drug from, or changing a drug tier within, their formulary during a policy term.

State law already requires coverage for a drug if an insured was already using that drug for a chronic illness and the attending health care provider states in writing that the drug is medically necessary. State statute also provides strict step-therapy standards which include a physician override provision. Furthermore, the Department of Insurance developed formal regulations to assure the integrity of formularies after issuing a regulatory bulletin (HC-113).

Passage of this legislation would seriously compromise a carrier's ability to hold pharmaceutical companies accountable for rising drug costs doing consumers seeking affordable health coverage a disservice. Some considerations: Daraprim, a drug used by some AIDS and cancer patients to treat life-threatening parasitic infections, increased from $13.50 a pill to $750 a pill overnight. Sovaldi, the drug used to treat Hepatitis C, topped out at $80,000 for a 30-day supply and EpiPen increased from $100 in 2007 to $608 for a two-pack just a few years later. These price hikes alone threatened to cripple state and household budgets across the country.

HB 6622 is just one of the many pharmacy bills before you this session that are opposed by the Association. On average, pharmaceutical prices increase premiums between 15% and 20% a year. the reasons are varied. The number of overall prescriptions issued has increased dramatically, new biologic specialty drugs that cost hundreds of thousands of dollars have come online faster, and consumer demand continues to escalate. Many of the most heavily promoted

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drugs often have no better clinical outcomes than their less expensive counterparts. Consider the fiscal note attached on a similar bill in 2019:

> *HB 6096 - The bill will result in cost to the state employee and retiree health plan of $3.7 million in FY 20 and an annualized cost of approximately $7.4 million from prohibiting the pharmacy benefit manager (PBM) from reclassifying a brand name drug unless a generic is provided in a lower cost tier. Pursuant to the SEBAC 2017 Agreement the state has a four-tiered pharmacy benefit: preferred generic, generic, preferred brand and non-preferred brand. The bill precludes reclassifying brand name drugs on the preferred drug list/formulary drug a plan year.*

Furthermore, it's important to remember that Connecticut's authority to enact these provisions applies ***only*** to the fully-insured market which effects less than 35% of state's population. That's true as well for all the other bills under consideration by the Committee. Fully-insured employers are generally small businesses who can't afford to take the risk associated with becoming self-insured. Large employers, that are ***self-insured and therefore federally regulated,*** would still have the ability to manage their own formularies.

Thank you for your consideration.

280 Trumbull Street | 27th Floor | Hartford, CT 06103-3597 | 860.275.8372 | Fax 860.541.4923 | www.ctahp.com